R590. Insurance, Administration. (Effective 7-30-07)
R590-126. Accident and Health Insurance Standards.
R590-126-1. Authority.

This rule is issued by the insurance commissioner pursuant to the following provisions of the Utah Insurance Code:

(1) Subsection 31A-2-201(3)(a) authorizes rules to implement the Insurance Code;

(2) Sections 31A-2-202 and 31A-23a-412 authorize the commissioner to request reports, conduct examinations, and inspect records of any licensee;

(3) Subsection 31A-22-605(4) requires the commissioner to adopt rules to establish standards for disclosure in the sale of, and benefits to be provided by individual and franchise accident and health polices;

(4) Section 31A-22-623 authorizes the commissioner to establish by rule minimum standards of coverage for dietary products for inborn metabolic errors;

(5) Section 31A-22-626 authorizes the commissioner to establish by rule minimum standards of coverage for diabetes for accident and health insurance;

(6) Subsection 31A-23a-402(8) authorizes the commissioner to define by rule acts and practices that are unfair and unreasonable; and

(7) Subsection 31A-26-301(1) authorizes the commissioner to set standards for timely payment of claims.

R590-126-2. Purpose and Scope.

(1) Purpose. The purpose of this rule is to provide reasonable standardization and simplification of terms and coverages of insurance policies in order to facilitate public understanding and comparison and to prohibit provisions which may be misleading or confusing in connection either with the purchase of such coverages or with the settlement of claims, and to provide for full disclosure in the sale of such insurance.

(2) Scope.

(a) This regulation applies to:

(i) all individual accident and health insurance policies and group supplemental health policies and certificates, delivered or issued for delivery in this state on and after January 1, 2006, that are not specifically exempted from this regulation, regardless of:

(A) whether the policy is issued to an association; a trust; a discretionary group; or other similar grouping; or

(B) the situs of delivery of the policy or contract; and

(ii) all dental plans and vision plans.

(b) This rule shall not apply to:

(i) employer accident and health insurance, as defined in Section 31A-22-502;

(ii) policies issued to employees or members as additions to franchise plans in existence on the effective date of this regulation;

(iii) Medicare supplement policies subject to Section 31A-22-620; or

(iv) civilian Health and Medical Program of the Uniformed

Services, Chapter 55, title 10 of the United States Code, CHAMPUS supplement insurance policies.

(3) The requirements contained in this regulation shall be in addition to any other applicable regulations previously adopted.

R590-126-3. Definitions.

In addition to the definitions of Section 31A-1-301 and Subsection 31A-22-605(2), the following definitions shall apply for the purpose of this rule.

(1) "Accident," "accidental injury," and "accidental means" shall be defined to employ result language and shall not include words that establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

(a) The definition shall not be more restrictive than the following: "injury" or "injuries" means accidental bodily injury sustained by the insured person that is the direct cause of the condition for which benefits are provided, independent of disease or bodily infirmity or any other cause and that occurs while the insurance is in force.

(b) Unless otherwise prohibited by law, the definition may exclude injuries for which benefits are paid under worker's compensation, any employer's liability or similar law, or a motor vehicle no-fault plan.

(2) "Adult Day Care" shall mean a facility duly licensed and operating within the scope of such license. Adult Day Care facility may not be defined more restrictively than providing continuous care and supervision for three or more adults 18 years of age and over for at least four but less than 24 hours a day, that meets the needs of functionally impaired adults through a comprehensive program that provides a variety of health, social, recreational, and related support services in a protective setting.

(3) "Certificate of Completion" shall mean a document issued by the Utah Board of Education to a person who completes an approved course of study not leading to a diploma, or to one who passes a challenge for that same course of study, or to one whose out-of-state credentials and certificate are acceptable to the Board.

(4) "Complications of Pregnancy" shall mean diseases or conditions the diagnoses of which are distinct from pregnancy but are adversely affected or caused by pregnancy and not associated with a normal pregnancy.

(a) "Complications of Pregnancy" include acute nephritis, nephrosis, cardiac decompensation, ectopic pregnancy which is terminated, a spontaneous termination of pregnancy when a viable birth is not possible, puerperal infection, eclampsia, pre-eclampsia and toxemia.

(b) This definition does not include false labor, occasional spotting, doctor prescribed rest during the period of pregnancy, morning sickness, and conditions of comparable severity associated with management of a difficult pregnancy.

(5) "Conditionally Renewable" means renewal can be declined

by class, by geographic area or for stated reasons other than deterioration of health.

(6) "Convalescent Nursing Home," "extended care facility," or "skilled nursing facility" shall mean a facility duly licensed and operating within the scope of such license.

(7) "Cosmetic Surgery" or "Reconstructive Surgery" shall mean any surgical procedure performed primarily to improve physical appearance.

(a) This definition does not include surgery, which is necessary:

(i) to correct damage caused by injury or sickness;

(ii) for reconstructive treatment following medically necessary surgery;

(iii) to provide or restore normal bodily function; or

(iv) to correct a congenital disorder that has resulted in a functional defect.

(b) This provision does not require coverage for preexisting conditions otherwise excluded.

(8) "Custodial Care" shall mean a Plan of Care, which does not provide treatment for sickness or injury, but is only for the purpose of meeting personal needs and maintaining physical condition when there is no prospect of effecting remission or restoration of the patient to a condition in which care would not be required. Such care may be provided by persons without nursing skills or qualifications. If a nursing care facility is only providing custodial or residential care, the level of care may be so characterized.

(9) "Disability Income" shall mean income replacement as defined in Section 31A-1-301.

(10) "Elimination Period" or "Waiting Period" means the length of time an insured shall wait before benefits are paid under the policy.

(11) "Enrollment Form" shall mean application as defined in Section 31A-1-301.

(12) "Experimental Treatment" is defined as medical treatment, services, supplies, medications, drugs, or other methods of therapy or medical practices, which are not accepted as a valid course of treatment by the Utah Medical Association, the U.S. Food and Drug Administration, the American Medical Association, or the Surgeon General.

(13) "Group Supplemental Health Insurance" means group accident and health insurance policies and certificates providing hospital confinement indemnity, accident only, specified disease, specified accident or limited benefit health coverage.

(14) "Guaranteed Renewable" means renewal cannot be declined by the insurance company for any reasons, but the insurance company can revise rates on a class basis.

(15) "Home Health Agency" shall mean a public agency or private organization, or subdivision of a health care facility, licensed and operating within the scope of such license.

(16) "Home Health Aide" shall mean a person who obtains a Certificate of Completion, as required by law, which allows performance of health care and other related services under the supervision of a registered nurse from the home health agency, or

performance of simple procedures as an extension of physical, speech, or occupational therapy under the supervision of licensed therapists.

(17) "Home Health Care" shall mean services provided by a home health agency.

(18) "Homemaker" shall mean a person who cares for the environment in the home through performance of duties such as housekeeping, meal planning and preparation, laundry, shopping and errands.

(19) "Homemaker/Home Health Aide" shall mean a person who has obtained a Certificate of Completion, as required by law, which allows performance of both homemaker and home health aide services, and who provides health care and other related services under the supervision of a registered nurse from the home health agency or under the supervision of licensed therapists.

(20) "Hospice" shall mean a program of care for the terminally ill and their families which occurs in a home or in a health care facility and which provides medical, palliative, psychological, spiritual, or supportive care and treatment and is licensed and operating within the scope of such license.

(21) "Hospital" means a facility that is licensed and operating within the scope of such license. This definition may not preclude the requirement of medical necessity of hospital confinement or other treatment.

(22) "Intermediate Nursing Care" shall mean nursing services provided by, or under the supervision of, a registered nurse. Such care shall be for the purpose of treating the condition for which confinement is required.

(23) "Medical Necessity" means:

(a) health care services or products that a prudent health care professional would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is:

(i) in accordance with generally accepted standards of medical practice in the United States;

(ii) clinically appropriate in terms of type, frequency, extent, site, and duration;

(iii) not primarily for the convenience of the patient, physician, or other health care provider; and

(iv) covered under the contract;

(b) when a medical question-of-fact exists medical necessity shall include the most appropriate available supply or level of service for the individual in question, considering potential benefits and harms to the individual, and known to be effective.

(i) For interventions not yet in widespread use, the effectiveness shall be based on scientific evidence.

(ii) For established interventions, the effectiveness shall be based on:

(A) scientific evidence;

(B) professional standards; and

(C) expert opinion.

(24) "Medicare" means the "Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended."

(25) "Medicare Supplement Policy" shall mean an individual, franchise, or group policy of accident and health insurance, other than a policy issued pursuant to a contract under section 1876 of the federal Social Security Act, 42 U.S.C. section 1395 et seq., or an issued policy under a demonstration project specified in 41 U.S.C. Section 1395ss(g)(1), that is advertised, marketed, or primarily designed as a supplement to reimbursements under Medicare for hospital, medical, or surgical expenses of persons eligible for Medicare.

(26) "Mental or Nervous Disorders" may not be defined more restrictively than a definition including neurosis, psychoneurosis, psychosis, or any other mental or emotional disease or disorder which does not have a demonstrable organic cause.

(27) "Non-Cancelable" means renewal cannot be declined nor can rates be revised by the insurance company.

(28) "Nurse" may be defined so that the description of nurse is restricted to a type of nurse, such as registered nurse, or licensed practical nurse. If the words "nurse" or "registered nurse" are used without specific instruction, then the use of such terms requires the insurer to recognize the services of any individual who qualifies under such terminology in accordance with applicable statutes or administrative rules.

(29) "Nurse, Licensed Practical" shall mean a person who is registered and licensed to practice as a practical nurse.

(30) "Nurse, Registered" shall mean any person who is registered and licensed to practice as a registered nurse.

(31) "Nursing Care" shall mean assistance provided for the health care needs of sick or disabled individuals, by or under the direction of licensed nursing personnel.

(32) "One Period of Confinement" shall mean consecutive days of in-hospital service received as an inpatient, or successive confinements when discharge from and readmission to the hospital occurs within a period of time of not more than 90 days or three times the maximum number of days of in-hospital coverage provided by the policy up to a maximum of 180 days.

(33) "Optionally Renewable" means renewal is at the option of the insurance company.

(34) "Partial Disability" shall be defined in relation to the individual's inability to perform one or more, but not all, of; the major, important, or essential duties of employment or occupation; customary duties of a homemaker or dependent; or may be related to a percentage of time worked or to a specified number of hours or to compensation.

(35) "Personal Care" shall mean assistance, under a plan of care by a home health agency, provided to persons in activities of daily living.

(36) "Personal Care Aide" shall mean a person who obtains a Certificate of Completion, as required by law, which allows that person to assist in the activities of daily living and emergency first aid, and who must be supervised by a registered nurse from the home health agency.

(37) "Physician" may be defined by including words such as qualified physician or licensed physician. The use of such terms

requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when such services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.

(38) "Preexisting Condition."

(a) Except as provided in Section (b), a preexisting condition shall not be defined more restrictively than the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within a two year period preceding the effective date of the coverage of the insured person or a condition for which medical advice or treatment was recommended by a physician or received from a physician within a two year period preceding the effective date of the coverage of the insured person.

(b) A specified disease insurance policy shall not define preexisting condition more restrictively than a condition which first manifested itself within six months prior to the effective date of coverage or which was diagnosed by a physician at any time prior to the effective date of coverage.

(39) "Probationary Period" shall mean the period of time following the date of issuance or effective date of the policy before coverage begins for all or certain conditions.

(40) "Residential Health Care Facility" shall mean a publicly or privately operated and maintained facility providing personal care to residents who require protected living arrangements which is licensed and operating within the scope of such license.

(41) "Residual Disability" shall be defined in relation to the individual's reduction in earnings and may be related either to the inability to perform some part of the major, important, or essential duties of employment or occupation, or to the inability to perform all usual duties for as long as is usually required.

(42) "Respite Care" shall mean provision of temporary support to the primary caregiver of the aged, disabled, or handicapped individual insured, by taking over the tasks of that person for a limited period of time. The insured may receive care in the home, or other appropriate community location, or in an appropriate institutional setting.

(43)(a) "Scientific evidence" means:

(i) scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or

(ii) findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes.

(b) Scientific evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

(44) "Sickness" means illness, disease, or disorder of an insured person.

(45) "Skilled Nursing Care" shall mean nursing services provided by, or under the supervision of, a registered nurse. Such care shall be for the purpose of treating the condition for which the confinement is required and not for the purpose of providing intermediate or custodial care.

(46) "Therapist" may be defined as a professionally trained or duly licensed or registered person, such as a physical therapist, occupational therapist, or speech therapist, who is skilled in applying treatment techniques and procedures under the general direction of a physician.

(47)(a) "Total Disability" shall mean an individual who:

(i) is not engaged in employment or occupation for which he is or becomes qualified by reason of education, training or experience; and

(ii) is unable to perform all of the substantial and material duties of his or her regular occupation or words of similar import.

(b) An insurer may require care by a physician other than the insured or a member of the insured's immediate family.

(c) The definition may not exclude benefits based on the individual's:

(i) ability to engage in any employment or occupation for wage or profit;

(ii) inability to perform any occupation whatsoever, any occupational duty, or any and every duty of his occupation; or

(iii) inability to engage in any training or rehabilitation program.

(48)(a) "Usual and Customary" shall mean the most common charge for similar services, medicines or supplies within the area in which the charge is incurred.

(b) In determining whether a charge is usual and customary, insurers shall consider one or more of the following factors:

(i) the level of skill, extent of training, and experience required to perform the procedure or service;

(ii) the length of time required to perform the procedure or services as compared to the length of time required to perform other similar services;

(iii) the severity or nature of the illness or injury being treated;

(iv) the amount charged for the same or comparable services, medicines or supplies in the locality; the amount charged for the same or comparable services, medicines or supplies in other parts of the country;

(v) the cost to the provider of providing the service, medicine or supply; and

(vi) other factors determined by the insurer to be appropriate.

(49) "Waiting Period" shall mean "Elimination Period."

R590-126-4. Prohibited Policy Provisions.

(1) Probationary periods.

(a) A policy shall not contain provisions establishing a probationary period during which no coverage is provided under the policy, subject to the further exception that a policy may specify

a probationary period not to exceed six months for specified diseases or conditions and losses resulting from disease or condition related to:

(i) adenoids;

(ii) appendix;

(iii) disorder of reproductive organs;

(iv) hernia;

(v) tonsils; and

(vi) varicose veins.

(b) The six-month period in Subsection (1)(a) may not be applicable where such specified diseases or conditions are treated on an emergency basis.

(c) Accident policies may not contain probationary or waiting periods.

(d) A probationary or waiting period for a specified disease policy shall not exceed 30 days.

(2) Preexisting conditions.

(a) Except as provided in Subsections (b) and (c), a policy shall not exclude coverage for a loss due to a preexisting condition for a period greater than 12 months following the issuance of the policy or certificate where the application or enrollment form for the insurance does not seek disclosure of prior illness, disease or physical conditions or prior medical care and treatment and the preexisting condition is not specifically excluded by the terms of the policy or certificate.

(b) A specified disease policy shall not exclude coverage for a loss due to a preexisting condition for a period greater than six months following the issuance of the policy or certificate, unless the preexisting condition is specifically excluded.

(c) A hospital confinement indemnity policy shall not exclude a preexisting condition for a period greater than 12 months following the effective date of coverage of an insured person unless the preexisting condition is specifically and expressly excluded.

(3) Hospital indemnity. Policies providing hospital confinement indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the federal government.

(4) Limitations or exclusions. A policy shall not limit or exclude coverage or benefits by type of illness, accident, treatment or medical condition, except as follows:

(a) abortion;

(b) acupuncture and acupressure services;

(c) administrative charges for completing insurance forms, duplication services, interest, finance charges, or other administrative charges, unless otherwise required by law;

(d) administrative exams and services;

(e) alcoholism and drug addictions;

(f) allergy tests and treatments;

(g) aviation;

(h) axillary hyperhidrosis;

(i) benefits provided under:

(i) Medicare or other governmental program, except Medicaid;

(ii) state or federal worker's compensation; or

(iii) employer's liability or occupational disease law.

(j) cardiopulmonary fitness training, exercise equipment, and membership fees to a spa or health club;

(k) charges for appointments scheduled and not kept;

(l) chiropractic;

(m) complementary and alternative medicine;

(n) corrective lenses, and examination for the prescription or fitting thereof, but policies may not exclude required lens implants following cataract surgery;

(o) cosmetic surgery; reversal, revision, repair, complications, or treatment related to a non-covered cosmetic surgery. This exclusion does not apply to reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part; or reconstructive surgery because of congenital disease or anomaly of a covered dependent child that has resulted in a functional defect;

(p) custodial care;

(q) dental care or treatment, except dental plans;

(r) dietary products, except as required by R590-194;

(s) educational and nutritional training, except as required by R590-200;

(t) experimental and/or investigational services;

(u) felony, riot or insurrection, when the insured is a voluntary participant;

(v) foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet, including orthotics. The exclusion of routine foot care does not apply to cutting or removal of corns, calluses, or nails when provided to a person who has a systemic disease, such as diabetes with peripheral neuropathy or circulatory insufficiency, of such severity that unskilled performance of the procedure would be hazardous;

(w) gastric or intestinal bypass services including lap banding, gastric stapling, and other similar procedures to facilitate weight loss; the reversal, or revision of such procedures; or services required for the treatment of complications from such procedures;

(x) gene therapy;

(y) genetic testing;

(z) hearing aids, and examination for the prescription or fitting thereof;

(aa) illegal activities, limited to losses related directly to the insured's voluntary participation;

(bb) incarceration, with respect to disability income policies;

(cc) infertility services, except as required by R590-76;

(dd) interscholastic sports, with respect to short-term nonrenewable policies;

(ee) mental or emotional disorders;

(ff) motor vehicle no-fault law, except when the covered person is required by law to have no-fault coverage, the exclusion applies to charges up to the minimum coverage required by law

whether or not such coverage is in effect;

(gg) nuclear release;

(hh) preexisting conditions or diseases as allowed under Subsection R590-126-4(2), except for coverage of congenital anomalies as required by Section 31A-22-610;

(ii) pregnancy, except for complications of pregnancy;

(jj) refractive eye surgery;

(kk) rehabilitation therapy services (physical, speech, and occupational), unless required to correct an impairment caused by a covered accident or illness;

(ll) respite care;

(mm) rest cures;

(nn) routine physical examinations;

(oo) service in the armed forces or units auxiliary to it;

(pp) services rendered by employees of hospitals, laboratories or other institutions;

(qq) services performed by a member of the covered person's immediate family;

(rr) services for which no charge is normally made in the absence of insurance;

(ss) sexual dysfunction;

(tt) shipping and handling, unless otherwise required by law;

(uu) suicide, sane or insane, attempted suicide, or intentionally self-inflicted injury;

(vv) telephone/electronic consultations;

(ww) territorial limitations outside the United States;

(xx) terrorism, including acts of terrorism;

(yy) transplants;

(zz) transportation;

(aaa) treatment provided in a government hospital, except for hospital indemnity policies;

(bbb) war or act of war, whether declared or undeclared; or

(ccc) others as may be approved by the commissioner.

(5) Waivers. This rule shall not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases, physical condition or extra hazardous activity. Where waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required.

(6) Commissioner authority. Policy provisions precluded in this section shall not be construed as a limitation on the authority of the commissioner to prohibit other policy provisions that in the opinion of the commissioner are unjust, unfair or unfairly discriminatory to the policyholder, beneficiary or a person insured under the policy.

R590-126-5. General Requirements.

(1) Policy definitions. No policy subject to this rule may contain definitions respecting the matters defined in Section R590-126-3 unless such definitions comply with the requirements of that section.

(2) Rights of spouse. The following provisions apply to policies that provide coverage to a spouse of the insured:

(a) A policy may not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than for nonpayment of premium.

(b) A policy shall provide that in the event of the insured's death the spouse of the insured shall become the insured.

(c) The age of the younger spouse shall be used as the basis for meeting the age and durational requirements of the noncancellation or renewal provisions of the policy. However, this requirement may not prevent termination of coverage of the older spouse upon attainment of stated age limit in the policy, so long as the policy may be continued in force as to the younger spouse to the age or for durational period as specified in said definition.

(3) Cancellation, Renewability, and Termination.

The terms "conditionally renewable," "guaranteed renewable," "noncancellable," or "optionally renewable" shall not be used without further explanatory language in accordance with the disclosure requirements of Subsection R590-126-6(2).

(a) Conditionally renewable. The term "conditionally renewable" may be used only in a policy which the insured may have the right to continue in force by the timely payment of premiums at least to age 65, during which period the insurer has no right to make any unilateral change to the detriment of the insured while the policy is in force. However, the insurer, at its option, and by timely notice, may decline renewal for reasons stated in the policy, or may make changes in premium rates by classes.

(b) Guaranteed renewable. The term "guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums at least to age 65, during which period the insurer has no right to make any unilateral change to the detriment of the insured while the policy is in force, except that the insurer may make changes in premium rates by classes.

(c) Noncancellable. The term "noncancellable" may be used only in a policy that the insured has the right to continue in force by the timely payment of premiums until the age of 65, during which period the insurer has no right to make unilaterally any change in any provision of the policy to the detriment of the insured.

(d) Optionally renewable. The term "optionally renewable" may be used only in a policy which the insured may have the right to continue in force by the timely payment of premiums at least to age 65, during which period the insurer has no right to make any unilateral change in any provision of the policy while the policy is in force. However, the insurer, at its option, and by timely notice, may decline renewal of the policy or may make changes in premium rates by classes.

(e) Notice of nonrenewal shall be given 90 days prior to nonrenewal.

(f) A policy may not be cancelled or nonrenewed solely on the grounds of deterioration of health.

(g) Termination of the policy shall be without prejudice to a continuous loss that commenced while the policy or certificate was in force. The continuous total disability of the insured may be a condition for the extension of benefits beyond the period the policy was in force, limited to the duration of the benefit period, if any, or payment of the maximum benefits.

(4) Optional insureds. When accidental death and dismemberment coverage is part of the accident and health insurance coverage offered under the contract, the insured shall have the option to include all insureds under the coverage and not just the principal insured.

(5) Military service. If a policy contains a status-type military service exclusion or a provision that suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to the person on a pro rata basis.

(6) Pregnancy benefit extension. In the event the insurer cancels or refuses to renew a policy providing pregnancy benefits, the policy shall provide an extension of benefits for a pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force. This requirement does not apply to a policy that is canceled for the following reasons:

(a) the insured fails to pay the required premiums in accordance with the terms of the plan; or

(b) the insured person performs an act or practice that constitutes fraud in connection with the coverage or makes an intentional misrepresentation of material fact under the terms of the coverage.

(7) Post hospital admission requirement. A policy providing convalescent or extended care benefits following hospitalization shall not condition the benefits upon admission to the convalescent or extended care facility within a period of less than 14 days after discharge from the hospital.

(8) Transplant donor coverage. A policy providing coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy or certificate, after benefits for the recipient's own expenses have been paid.

(9) Recurrent disability. A policy may contain a provision relating to recurrent disabilities, but a provision relating to recurrent disabilities shall not specify that a recurrent disability be separated by a period greater than 6 months.

(10) Time limit for occurrence of loss.

(a) Accidental death and dismemberment benefits shall be payable if the loss occurs within 180 days from the date of the accident, irrespective of total disability.

(b) Disability income benefits, if provided, shall not require the loss to commence less than 30 days after the date of accident, nor shall any policy that the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the coverage was in force.

(11) Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits.

(12) A policy providing coverage for fractures or dislocations may not provide benefits only for "full or complete" fractures or dislocations.

(13) Specified disease, also known as critical illness, dread disease, etc., insurance sold in conjunction with another insurance product, including but not limited to life insurance or annuities, shall be in the form of a separate endorsement complying with all provisions of this rule. Specified Disease insurance shall not be incorporated into a life insurance policy or annuity contract.

(14) Notice of premium change. A notice of change in premium shall be given no fewer than 45 days before the renewal date.

R590-126-6. Required Provisions.

(1) Applications.

(a) Questions used to elicit health condition information may not be vague and must reference a reasonable time frame in relation to the health condition.

(b) Completed applications shall be made part of the policy. A copy of the completed application shall be provided to the applicant prior to or upon delivery of the policy.

(c) All applications shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows:

"The (policy) (certificate) provides limited benefits. Review your (policy)(certificate) carefully."

(d) Application forms shall provide a statement regarding the pre-existing waiting period and the requirements to receive any applicable credit for previous coverage.

(e) An application form shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other accident and health insurance presently in force. A supplementary application or other form to be signed by the applicant containing the question may be used.

(f) All applications for dental and vision plans shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows:

"The (policy) (certificate) provides (dental) (vision) benefits only. Review your (policy) (certificate) carefully."

(2) Renewal and nonrenewal provisions. Accident and health insurance shall include a renewal, continuation or nonrenewal provision. The language or specification of the provision shall be consistent with the type of contract to be issued. The provision shall be appropriately captioned, shall appear on the

first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

(3) Endorsement acceptance.

(a) Except for endorsements by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the policy, all endorsements added to a policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder.

(b) After the date of policy issue, any endorsement that increases benefits or coverage with a concurrent increase in premium during the policy term, must be agreed to in writing signed by the policyholder, except if the increased benefits or coverage is required by law.

(4) Additional premium. Where a separate additional premium is charged for benefits provided in connection with endorsements, the premium charge shall be set forth in the policy or certificate.

(5) Benefit payment standard. A policy or certificate that provides for the payment of benefits based on standards described as usual and customary, reasonable and customary, or words of similar import shall include a definition of the terms and an explanation of the terms in its accompanying outline of coverage.

(6) Preexisting conditions. If a policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and be labeled as "Preexisting Condition Limitations."

(7) Accident Only Policies.

(a) An accident only policy or certificate shall contain a prominent statement on the first page of the policy or certificate, in either contrasting color or in boldface type at least equal to the size of type used for headings or captions of sections in the policy or certificate, as follows:

Notice to Buyer: This is an accident only (policy)(certificate) and it does not pay benefits for loss from sickness. Review your (policy)(certificate) carefully.

(b) Accident only policies or certificates that provide coverage for hospital or medical care shall contain the following statement in addition to the notice above:

This (policy)(certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.

(c) An accident-only policy providing benefits that vary according to the type of accidental cause shall prominently set forth in the outline of coverage the circumstances under which benefits are payable that are lesser than the maximum amount payable under the policy.

(8) Age limitation. If age is to be used as a determining factor for reducing the maximum aggregate benefits made available in the policy or certificate as originally issued, that fact shall be prominently set forth in the outline of coverage and schedule

page.

(9) Disappearance. If a policy or certificate includes a disappearance benefit, payment must be made within the time limits provided by R590-192-9 when proof of loss, satisfactory to the company, is filed and it is reasonable to assume death occurred, but a body cannot be found.

(10) Conversion privilege. If a policy or certificate contains a conversion privilege, it shall comply, in substance, with the following: The caption of the provision shall read "Conversion Privilege" or words of similar import. The provision shall indicate the persons eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person by whom the conversion privilege may be exercised. The provision shall specify the benefits to be provided on conversion or may state that the converted coverage will be as provided on a policy form then being used by the insurer for that purpose.

(11) Specified Disease Insurance Buyers Guide. An insurer, except a direct response insurer, shall give a person applying for specified disease insurance, a buyer's guide filed with the commissioner at the time of enrollment and shall obtain recipient's written acknowledgement of the guide's delivery. A direct response insurer shall provide the buyer's guide upon request, but not later than the time that the policy or certificate is delivered.

(12) Specified disease policies or certificates shall contain on the first page or attached to it in either contrasting color or in boldface type, at least equal to the size type used for headings or captions of sections in the policy or certificate, a prominent statement as follows:

Notice to Buyer: This is a specified disease (policy) (certificate). This (policy) (certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your (policy) (certificate) carefully with the outline of coverage and the buyer's guide.

(13) Hospital confinement indemnity and limited benefit health policies or certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following:

Notice to Buyer: This is a (hospital confinement indemnity) (limited benefit health) (policy)(certificate). This (policy)(certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.

(14) Basic hospital, basic medical-surgical, and basic hospital-medical surgical expense policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following:

Notice to Buyer: This is a (basic hospital) (basic medical-surgical) (basic hospital/medical-surgical) expense (policy)(certificate). This (policy)(certificate) provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage.

(15) Dental and vision coverage policies and certificates shall display prominently by type or stamp on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following:

Notice to Buyer: This (policy) (certificate) provides (dental) (vision) coverage only.

R590-126-7. Accident and Health Standards for Benefits.

The following standards for benefits are prescribed for the categories of coverage noted in the following subsections. An accident and health insurance policy or certificate subject to this rule shall not be delivered or issued for delivery unless it meets the required standards for the specified categories. This section shall not preclude the issuance of any policy or contract combining two or more categories set forth in Subsection 31A-22-605(5).

Benefits for coverages listed in this section shall include coverage of inborn metabolic errors as required by Section 31A-22-623 and Rule R590-194, and benefits for diabetes as required by Section 31A-22-626 and Rule R590-200, if applicable.

(1) Basic Hospital Expense Coverage.

Basic hospital expense coverage is a policy of accident and health insurance that provides coverage for a period of not less than 31 days during a continuous hospital confinement for each person insured under the policy, for expense incurred for necessary treatment and services rendered as a result of accident or sickness, and shall include at least the following:

(a) daily hospital room and board in an amount not less than:

(i) 80% of the charges for semiprivate room accommodations; or

(ii) $100 per day;

(b) miscellaneous hospital services for expenses incurred for the charges made by the hospital for services and supplies that are customarily rendered by the hospital and provided for use only during any one period of confinement in an amount not less than either:

(i) 80% of the charges incurred up to at least $3000; or

(ii) ten times the daily hospital room and board benefits; and

(c) hospital outpatient services consisting of:

(i) hospital services on the day surgery is performed;

(ii) hospital services rendered within 72 hours after injury, in an amount not less than $250 per accident; and

(iii) x-ray and laboratory tests to the extent that benefits for the services would have been provided if rendered to an in-patient of the hospital to an extent not less than $200;

(d) benefits provided under Subsections (a) and (b) may be provided subject to a combined deductible amount not in excess of $200.

(2) Basic Medical-Surgical Expense Coverage.

Basic medical-surgical expense coverage is a policy of accident and health insurance that provides coverage for each person insured under the policy for the expenses incurred for the necessary services rendered by a physician for treatment of an injury or sickness for and shall include at least the following:

(a) surgical services:

(i) in amounts not less than those provided on a current procedure terminology based relative value fee schedule, up to at least $1000 for one procedure; or

(ii) 80% of the reasonable charges.

(b) anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical service rendered by a physician other than the physician, or the physician assistant, performing the surgical services:

(i) in an amount not less than 80% of the reasonable charges; or

(ii) 15% of the surgical service benefit; and

(c) in-hospital medical services, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical care is required, in an amount not less than:

(i) 80% of the reasonable charges; or

(ii) $100 per day.

(3) Basic Hospital/Medical-Surgical Expense Coverage.

Basic hospital/medical-surgical expense coverage is a policy of accident and health which combines coverage and must meet the requirements of both Subsections R590-126-7(1) and (2).

(4) Hospital Confinement Indemnity Coverage.

(a) Hospital confinement indemnity coverage is a policy of accident and health insurance that provides daily benefits for hospital confinement on an indemnity basis.

(b) Coverage includes an indemnity amount of not less than $50 per day and not less than 31 days during each period of confinement for each person insured under the policy.

(c) Benefits shall be paid regardless of other coverage.

(5) Income Replacement Coverage.

Income replacement coverage is a policy of accident and health insurance that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination of both that:

(a) contains an elimination period no greater than:

(i) 90-days in the case of a coverage providing a benefit of one year or less;

(ii) 180 days in the case of coverage providing a benefit of more than one year but not greater than two years; or

(iii) 365 days in all other cases during the continuance of disability resulting from sickness or injury;

(b) has a maximum period of time for which it is payable

during disability of at least six months except in the case of a policy covering disability arising out of pregnancy, childbirth or miscarriage in which case the period for the disability may be one month. No reduction in benefits shall be put into effect because of an increase in Social Security or similar benefits during a benefit period;

(c) where a policy provides total disability benefits and partial disability benefits, only one elimination period may be required;

(d) a policy which provides for residual disability benefits may require a qualification period, during which the insured shall be continuously totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability;

(e) the provisions of this subsection do not apply to policies providing business buyout coverage.

(6) Accident Only Coverage.

Accident only coverage is a policy of accident and health insurance that provides coverage, singly or in combination, for death, dismemberment, disability or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under the policy shall be at least $1,000 and a single dismemberment amount shall be at least $500.

(7) Specified Accident Coverage.

Specified accident coverage is a policy of accident and health insurance that provides coverage for a specifically identified kind of accident, or accidents, for each person insured under the policy for accidental death or accidental death and dismemberment, combined with a benefit amount not less than $1,000 for accidental death, $1,000 for double dismemberment and $500 for single dismemberment.

(8) Specified Disease Coverage.

Specified disease coverage is a policy of accident and health insurance that provides coverage for the diagnosis and treatment of a specifically named disease or diseases, and includes critical illness coverages. Any such policy shall meet these general provisions. The policy shall also meet the standards set forth in the applicable Subsections R590-126-7(8)(b), (c) or (d).

(a) General Provisions.

(i) Policy designation. Policies covering a single specified disease or combination of specified diseases may not be sold or offered for sale other than as specified disease coverage under this Subsection (8).

(ii) Medical diagnosis. Any policy issued pursuant to this section which conditions payment upon pathological diagnosis of a covered disease, shall also provide that if a pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted instead.

(iii) Related conditions. Notwithstanding any other provision of this rule, specified disease policies shall provide benefits to any covered person, not only for the specified disease, but also for any other condition or disease directly caused or aggravated by the specified disease or the treatment of

the specified disease.

(iv) Renewability. Specified disease coverage shall be at least guaranteed renewable.

(v) Probationary period. No policy issued pursuant to this section may contain a probationary period greater than 30 days.

(vi) Medicaid disclaimer. Any application for specified disease coverage shall contain a statement above the signature of the applicant that no person to be covered for specified disease is also covered by any Title XIX program, designated as Medicaid or any similar name. Such statement may be combined with any other statement for which the insurer may require the applicant's signature.

(vii) Medical Care. Payments may be conditioned upon an insured person's receiving medically necessary care, given in a medically appropriate location, under a medically accepted course of diagnosis or treatment.

(viii) Other insurance. Benefits for specified disease coverage shall be paid regardless of other coverage.

(ix) Retroactive application of coverage. After the effective date of the coverage, or the conclusion of an applicable probationary period, if any, benefits shall begin with the first day of care or confinement, if such care or confinement is for a covered disease, even though the diagnosis is made at some later date.

(x) Hospice. Hospice care is an optional benefit, but if offered it shall meet the following minimum standards:

(A) eligibility for payment of benefits when the attending physician of the insured provides a written statement that the insured person has a life expectance of six months or less;

(B) fixed-sum payment of at least $50 per day; and

(C) lifetime maximum benefit of at least $10,000.

(b) Expense Incurred Benefits. The following benefit standards apply to specified disease coverage on an expense-incurred basis.

(i) Policy limits. A deductible amount not to exceed $250, an aggregate benefit limit of not less than $25,000 and a benefit period of not fewer than three years.

(ii) Copayment. Covered services provided on an outpatient basis may be subject to a copayment, which may not exceed 20%.

(iii) Covered Services. Covered services shall include the following:

(A) hospital room and board and any other hospital-furnished medical services or supplies;

(B) treatment by, or under the direction of, a legally qualified physician or surgeon;

(C) private duty nursing services of a registered nurse, or licensed practical nurse;

(D) x-ray, radium, chemotherapy and other therapy procedures used in diagnosis and treatment;

(E) blood transfusions, and the administration thereof, including expense incurred for blood donors;

(F) drugs and medicines prescribed by a physician;

(G) professional ambulance for local service to or from a local hospital;

(H) the rental of any respiratory or other mechanical apparatuses;

(I) braces, crutches and wheelchairs as are deemed necessary by the attending physician for the treatment of the disease;

(J) emergency transportation if, in the opinion of the attending physician, it is necessary to transport the insured to another locality for treatment of the disease;

(K) home health care with a written prescribed plan of care;

(L) physical, speech, hearing and occupational therapy;

(M) special equipment including hospital bed, toilette, pulleys, wheelchairs, aspirator, chux, oxygen, surgical dressings, rubber shields, colostomy and eleostomy appliances;

(N) prosthetic devices including wigs and artificial breasts;

(O) nursing home care for non-custodial services; and

(P) reconstructive surgery when deemed necessary by the attending physician.

(c) Per Diem Benefits. The following benefit standards apply to specified disease coverage on a per diem basis.

(i) Covered services shall include the following:

(A) hospital confinement benefit with a fixed-sum payment of at least $200 for each day of hospital confinement for at least 365 days, with no deductible amount permitted;

(B) outpatient benefit with a fixed-sum payment equal to one half the hospital inpatient benefits for each day of hospital or non-hospital outpatient surgery, radiation therapy and chemotherapy, for at least 365 days of treatment; and

(C) blood and plasma benefit with a fixed-sum benefit of at least $50 per day for blood and plasma, which includes their administration whether received as an inpatient or outpatient for at least 365 days of treatment.

(ii) Benefits tied to confinement in a skilled nursing home or home health care are optional. If a policy offers these benefits, they must equal the following:

(A) fixed-sum payment equal to one-half the hospital inpatient benefit for each day of skilled nursing home confinement for at least 180 days; and

(B) fixed-sum payment equal to one-fourth the hospital inpatient benefit for each day of home health care for at least 180 days.

(C) Any restriction or limitation applied to the benefits may not be more restrictive than those under Medicare.

(d) Lump Sum Benefits. The following benefit standards apply to specified disease coverage on a lump sum basis.

(i) Benefits shall be payable as a fixed, one-time payment, made within 30 days of submission to the insurer, of proof of diagnosis of the specified disease. Dollar benefits shall be offered for sale only in even increments of $1,000.

(ii) Where coverage is advertised or otherwise represented to offer generic coverage of a disease or diseases, e.g., "cancer insurance," "heart disease insurance," the same dollar amounts shall be payable regardless of the particular subtype of the disease, e.g., lung or bone cancer, with one exception. In the case of clearly identifiable subtypes with significantly lower

treatment costs, e.g., skin cancer, lesser amounts may be payable so long as the policy clearly differentiates that subtype and its benefits.

(9) Limited Benefit Health Coverage.

Limited benefit health coverage is a policy of accident and health insurance, other than a policy covering only a specified disease or diseases, that provides benefits that are less than the standards for benefits required under this Section. These policies or contracts may be delivered or issued for delivery with the outline of coverage required by Section R590-126-8.

R590-126-8. Outline of Coverage Requirements.

(1) Basic Hospital Expense Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsection R590-126-7(1). The items included in the outline of coverage must appear in the sequence prescribed:

TABLE I

(COMPANY NAME)

BASIC HOSPITAL EXPENSE COVERAGE

THIS (POLICY) (CERTIFICATE) PROVIDES LIMITED BENEFITS AND SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE COVERAGE

OUTLINE OF COVERAGE

Read Your (Policy)(Certificate) Carefully-This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY)(CERTIFICATE) CAREFULLY!

Basic hospital expense coverage is designed to provide, to persons insured, coverage for hospital expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services and hospital outpatient services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for physicians or surgeons fees or unlimited hospital expenses.

A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order: daily hospital room and board; miscellaneous hospital services; hospital out-patient services; and other benefits, if any.

A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits.

A description of policy provisions respecting renewability or

continuation of coverage, including age restrictions or any reservation of right to change premiums.

(2) Basic Medical-Surgical Expense Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsection R590-126-7(2). The items included in the outline of coverage must appear in the sequence prescribed:

TABLE II

(COMPANY NAME)

BASIC MEDICAL-SURGICAL EXPENSE COVERAGE

THIS (POLICY)(CERTIFICATE) PROVIDES LIMITED BENEFITS AND SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE COVERAGE

OUTLINE OF COVERAGE

Read Your (Policy)(Certificate) Carefully-This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!

Basic medical-surgical expense coverage is designed to provide, to persons insured, coverage for medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for hospital expenses or unlimited medical-surgical expenses.

A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:

surgical services;

anesthesia services;

in-hospital medical services; and

other benefits, if any.

A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits.

A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.

(3) Basic Hospital/Medical-Surgical Expense Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsections R590-126-7(3). The items included in the outline of

coverage must appear in the sequence prescribed.

TABLE III

(COMPANY NAME)

BASIC HOSPITAL/MEDICAL-SURGICAL EXPENSE COVERAGE

THIS (POLICY)(CERTIFICATE) PROVIDES LIMITED BENEFITS AND SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE COVERAGE

OUTLINE OF COVERAGE

Read Your (Policy)(Certificate) Carefully-This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!
Basic hospital/medical-surgical expense coverage is designed to provide, to persons insured, coverage for hospital and medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, hospital outpatient services, surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for unlimited hospital or medical surgical expenses.
A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:
daily hospital room and board;
miscellaneous hospital services;
hospital outpatient services;
surgical services;
anesthesia services;
in-hospital medical services; and
other benefits, if any.
A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits.
A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.

(4) Hospital Confinement Indemnity Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsection R590-126-7(4). The items included in the outline of coverage must appear in the sequence prescribed:

TABLE IV

(COMPANY NAME)

HOSPITAL CONFINEMENT INDEMNITY COVERAGE

THIS (POLICY)(CERTIFICATE) PROVIDES LIMITED BENEFITS
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT
INTENDED TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE

Read Your (Policy)(Certificate) Carefully-This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!
Hospital confinement indemnity coverage is designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for any benefits other than the fixed daily indemnity for hospital confinement and any additional benefit described below.
A brief specific description of the benefits in the following order:
daily benefit payable during hospital confinement; and
duration of benefit.
A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefit.
A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.
Any benefits provided in addition to the daily hospital benefit.

(5) Income Replacement Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsection R590-126-7(5). The items included in the outline of coverage must appear in the sequence prescribed:

TABLE V

(COMPANY NAME)

INCOME REPLACEMENT COVERAGE

THIS (POLICY) (CERTIFICATE) PROVIDES LIMITED BENEFITS
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED
TO COVER ALL EXPENSES

OUTLINE OF COVERAGE

Read Your (Policy)(Certificate) Carefully-This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY)(CERTIFICATE) CAREFULLY!
Income replacement coverage is designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.
A brief specific description of the benefits contained in the policy.
A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits.
A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.

(6) Accident Only Coverage.

An outline of coverage in the form prescribed below shall be issued in connection with policies meeting the standards of Subsection R590-126-7(6). The items included in the outline of coverage must appear in the sequence prescribed:

TABLE VI

(COMPANY NAME)

ACCIDENT ONLY COVERAGE

THIS (POLICY)(CERTIFICATE) PROVIDES LIMITED BENEFITS
BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED
TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE
Read Your (Policy) (Certificate) Carefully-This outline of coverage provides a very brief description of the important features of the coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY)(CERTIFICATE) CAREFULLY!
Accident only coverage is designed to provide, to persons insured, coverage for certain losses resulting from a covered accident ONLY, subject to any limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.
A brief specific description of the benefits.

A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits.
A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.

(7) Specified Accident Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates meeting the standards of R590-126-7(7). The items included in the outline of coverage must appear in the sequence prescribed:

TABLE VII

(COMPANY NAME)

SPECIFIED ACCIDENT COVERAGE

THIS (POLICY) (CERTIFICATE) PROVIDES LIMITED BENEFITS
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED
TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE

Read Your (Policy)(Certificate) Carefully-This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!
Specified accident coverage is designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of specified accidents. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.
A brief specific description of the benefits, including dollar amounts.
A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits.
A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.

(8) Specified Disease Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates meeting the standards of Subsection R590-126-7(8). The items included in the outline of coverage must appear in the sequence prescribed:

TABLE VIII

(COMPANY NAME)

SPECIFIED DISEASE COVERAGE

THIS (POLICY) (CERTIFICATE) PROVIDES LIMITED BENEFITS
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED
TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE
Specified disease coverage is designed only as a supplement to a comprehensive health insurance policy and should not be purchased unless you have this underlying coverage. Persons covered under Medicaid should not purchase it. Read the Buyer's Guide to Specified Disease Insurance to review the possible limits on benefits in this type of coverage.
Read Your (Policy) (Certificate) Carefully--This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company.
It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!
Specified disease coverages designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of specified diseases. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.
A brief specific description of the benefits, including dollar amounts.
A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits.
A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.

(9) Limited Benefit Health Coverage.

Except for dental or vision plans, an outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates which do not meet the standards of Subsections R590-126-7(1) through (8). The items included in the outline of coverage must appear in the sequence prescribed:

TABLE IX

(COMPANY NAME)

LIMITED BENEFIT HEALTH COVERAGE

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED
TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE

Read Your (Policy) (Certificate) Carefully-This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!
Limited benefit health coverage is designed to provide, to persons insured, limited or supplemental coverage.
A brief specific description of the benefits, including amounts.
A description of any provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits.
A description of provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.

(10) Dental Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with dental plan policies and certificates. The items included in the outline of coverage must appear in the sequence prescribed:

TABLE X

(COMPANY NAME)

DENTAL COVERAGE

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL DENTAL EXPENSES
OUTLINE OF COVERAGE

Read Your (Policy) (Certificate) Carefully-This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!
A brief specific description of the benefits.
A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits.
A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.

(11) Vision Coverage.

An outline of coverage in the form prescribed below shall be issued in connection with vision plan policies and certificates.

The items included in the outline of coverage must appear in the sequence prescribed:

TABLE XI

(COMPANY NAME)

VISION COVERAGE

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL VISION EXPENSES

OUTLINE OF COVERAGE

Read Your (Policy) (Certificate) Carefully--This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!
A brief specific description of the benefits.
A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits.
A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.

(12) An insurer shall deliver an outline of coverage to an applicant or enrollee prior to or upon the sale of an individual accident and health insurance policy as required in this rule.

(13) If an outline of coverage was delivered at the time of application or enrollment and the policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany the policy or certificate when it is delivered and contain the following statement in no less than 12 point type, immediately above the company name:

NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application, and the coverage originally applied for has not been issued.

(14) Outlines of coverage for hospital confinement indemnity, specified disease, or limited benefit policies, which are to be delivered to persons eligible for Medicare by reason of age shall contain the following language, which shall be printed on or attached to the first page of the outline of coverage:

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People With Medicare available from the company.

(15) Where the prescribed outline of coverage is inappropriate for the coverage provided by the policy or certificate, an alternate outline of coverage shall be submitted to the commissioner for prior approval.

(16) Advertisements may fulfill the requirements for outlines of coverage if they satisfy the standards specified for outlines of coverage in this rule.

R590-126-9. Replacement of Accident and Health Insurance Requirements.

(1) Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its producer, shall furnish the applicant, prior to issuance or delivery of the policy, the notice described in Subsection (2). The insurer shall retain a copy of the notice. A direct response insurer shall deliver to the applicant, upon issuance of the policy, the notice described in Subsection (3). In no event, however, will the notices be required in the solicitation of the following types of policies: accident-only and single-premium nonrenewable policies.

(2) The notice required by Subsection (1) for an insurer, other than a direct response insurer, shall provide, in substantially the following form:

TABLE XII

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND HEALTH INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by (insert company name) Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy. Health conditions which you may presently have, (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

You may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy.

This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

.....

(Date)
.....
(Applicant's Signature)

(3) The notice required by Subsection (1) for a direct response insurer shall be as follows:

TABLE XIII

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND HEALTH INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and health insurance and replace it with the policy delivered herewith issued by (insert company name) Insurance Company. Your new policy provides 30 days within which you may decide without cost whether you desire to keep the policy.
For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
You may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
(To be included only if the application is attached to the policy). If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (insert company name and address) within ten days if any information is not correct and complete, or if any past medical history has been left out of the application.
COMPANY NAME

R590-126-10. Enforcement Date.

The commissioner will begin enforcing the revised provision of this rule January 1, 2006.

R590-126-11. Severability.

If any provision of this rule or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of the provision to other persons or circumstances shall not be affected thereby.

KEY: health insurance

Date of Enactment or Last Substantive Amendment: April 9, 2007
Notice of Continuation: January 11, 2007
Authorizing, and Implemented or Interpreted Law: 31A-2-201; 31A-2-202; 31A-21-201; 31A-22-605; 31A-22-623; 31A-22-626; 31A-23a-402; 31A-26-301